The first part of this study appeared in the February Journal. This second, concluding part deals with the role and operations of a planning body, with leadership and with expert studies and consultation that may be involved, and draws conclusions.

BASIC FACTORS IN PLANNING FOR THE COORDINATION OF HEALTH SERVICES—PART II

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A Planning Structure

HEALTH and welfare groups generally recognize that some mechanism is necessary for community-wide or inter-organizational planning. In all cases studied, the federation was first and logically turned to when such questions arose. Where suitable mechanisms did not exist, as in Cincinnati, they had to be created.

It is less clearly recognized that these structures, to be effective in bringing about any integration, must have a past history relevant to this purpose, as well as current competence for decision making.

A planning council or federation serves as such a mechanism first because it provides a meeting ground for the various groups and organizations concerned with any (voluntary) community policy decision. This structure contributes specifically to coordination when it has an identifiable history furthering cooperation among agencies and has been able to take an encompassing view of specific local rivalries. Integration was more readily achieved in communities where the planning group had already established a reputation of impartiality, objectivity, and wide community interest. Efforts failed when this condition was lacking. In some communities the federation was closely identified with the aims of one institution (usually the hospital) and was not relied upon by other groups. In other communities the federation was identified primarily with certain social, ethnic, or economic sectors and could not bring other sectors into effective planning.

In the two cases of fully successful integration, the federation conformed to this image; it had for many years brought together all groups involved in planning for the chronically ill (although not necessarily all other community groups). In two cases of relative failure, the federation had in the past dealt with some of the groups only, and current efforts to involve the others failed, presumably because the basis for confidence had not been developed.

It can be concluded that the concept of wide interagency cooperation becomes a significant factor in planning by federations only when it is to be assiduously pursued. When it is accepted it enables the planning organization to provide one arena in which special interest groups can relax their single-minded attention to internal goals; it reassures weaker organizations about their relative position vis-a-vis

more powerful ones; it makes possible a perspective wider than that of any one organization.

This function is especially important in the health field when it touches upon nonmedical organizations. Hospitals are usually so powerful that other related organizations become fearful of that power and resist with special vigor all efforts at coordination. In all communities studied, agencies and institutions reported a uniform fear of being "swallowed up" or dominated by the hospital. This fear operated as a major block to integrating efforts over the years and accounted in large part for the delay in reaching agreements, even when the community planning history and environment was favorable. A planning body with a reputation for objectivity and commitment to voluntary cooperative action was able to allay these anxieties and slowly bring the parties to some agreement about future relationships.

This position in the successful communities was achieved over years of consciously planned effort. These led to a community image of the effective federation as a body which stands for a few principles but takes few stands on details. As an organization it does have tensile strength to channelize the energies, moneys, personalities, and enthusiasms of the many diverse groups which go to make up the community, and does so in "best interests of the community." The absence of this image is a serious flaw in any effort to extend cooperation or coordination among agencies.

This analysis does not imply that federations never evolve specific plans of action and never use the obvious influence and power inherent in their fund-raising efforts. However, in successful cases the specific plans which receive the full weight of federation support emerged from the foundation of cooperative emphasis and were built upon voluntary agreements among diverse organizations. In the least successful cases, the federation early chose to support construction of specific rehabilitation centers, and this early choice of goal seems to have militated against the later efforts to develop other patterns of interagency cooperation.

It is clear from informants that individuals representing federations, as well as individuals from other organizations, had clear-cut plans to offer, but these were all given consideration without the federation as an organization acting to favor one against the other. To illustrate, in the successful cases federation committee reports which came in with strong minority dissents were received but not adopted and new committees were appointed to reconcile the differences. On the other hand, similar reports adopted as a plan of action in the less successful cases did not lead to cooperation.

The operations as well as the character of the planning body needs to be understood. These planning structures served four practical and essential purposes:

1. A channel of communication
2. A forum for negotiations
3. A springboard for leadership
4. A means to goal setting

Whenever patterns of agency operations are to be changed, many influences begin to operate. An open channel of communication must be established among the various parties so that new ideas can be spread, objections tested, and counter proposals understood. Agreement about a change is wholly dependent upon the diffusion of new ideas and their acceptance—upon clear understanding and opportunity to modify proposals to accommodate vital self-interests. In the successful cases, these channels led through the federation, and all parties reported that their first thought was to find out, through federation, what other groups were thinking, what other ideas were relevant, and what facts bore on the problem. In the

less successful cases the communication was incomplete. Some organizations were excluded from the deliberations, or there was no channel in federation in which all groups had confidence; there was no functioning committee, or the officers and staff were considered less than impartial.

The federations in successful cases served as a neutral forum for negotiations which the several agencies and power groups required to test and modify private ideas. It is difficult for any community-wide organization to assure neutrality in such a forum, for its own leadership with its own power inevitably develops clear-cut proposals of its own. To be effective, the image of a federation as just another power group with competing plans needs to be modified. In successful cases this was achieved by persistent emphasis upon voluntary agreement between strong and weak parties alike for goals which superseded the interests of any one organization. Thus, unpopular or weak organizations were assured some acceptable place in the emergent planning even though it meant a major change in their operations. This development was furthered when central planning organization called attention to certain community needs not met by the agencies currently operating in the field. This most frequently involved stress upon home care and noninstitutional services which were relatively underdeveloped in each city.

Federations also provided certain community leaders a springboard for their activity. Relatively few trustee and professional leaders in health and welfare in these cities were unaffected by their primary commitment to one specific agency or hospital. The few in each community who attempted to understand the problem of all agencies fairly and objectively, or to view community needs as broader than the aims of any one agency, required some base of social organization from which to speak on equal terms with leadership of individual agencies. This organizational base was provided in the federation in every city. A small handful of men had left behind their base of activity in one or another of the agencies as their community interests widened. In the most successful cases, these individuals retained only nominal positions on the boards of individual agencies, but retained community influence, nevertheless, by virtue of social or financial eminence.

Finally, a central planning organization serves as one channel for the development of community goals and standards which can be more encompassing than the goals of any one agency with limited functions. The evolution of these goals is complex and adoption by a central planning agency is not equivalent to adoption by its associated agencies. In fact, none of the planning goals in the six study communities were adopted by agencies except through the processes described in this report. Nevertheless, all agencies do establish goals and standards for their policy making, and their decisions are affected by the external guides to which agency trustees refer as they make up their minds. Central federations are not automatically these referrants for standards, but they can and do serve this purpose. In fact, it can be assumed that central welfare planning is effective in direct ratio to the extent that agencies adopt its goals as guides for their own action.

The Role of Leadership

The term "leadership" is frequently used, but its definition is elusive. These studies did not attempt to analyze in depth individual characteristics, but they did clarify the unique contribution which individual leadership still plays in our highly organized culture. In each

city, one or two individuals (usually laymen trustees) were identified by all respondents as playing the central role in the planning. In each instance, one person was specified, without contradiction, as having originated the idea for some new relationship between the institutions studied and as having had this idea well in advance of any formal or professional study of chronic illness. These individuals held positions of policy or of social or financial eminence. They became the spearhead of all succeeding action and the architects of the final plan.

Certain distinctive, if general, attributes can be identified in leadership in the successful cases, as distinguished from the unsuccessful ones. Successful leaders were, first of all, capable of bridging the interests of trustee groups of the constituent agencies. They were trusted and respected by the diverse subgroups of their community, regardless of the ethnic, cultural, social, or economic differences which divided them. In most instances they emerged from the oldest settled group and were located in the highest rank of social and financial influence. For reasons not identifiable by this study, they were also trusted by groups of later settlement, with quite different social and financial positions. Respondents attributed this unusual capacity, in part, to a lifetime of effort to become familiar with all facets of community life, not limited to the group or class in which the individual was born; in part to a real acceptance of and respect for differences in opinion; and in part to a commitment to community rather than subgroup or agency goals. In the cases of failure, the leadership was rather respected or feared by some groups and powerful in others, so that the ability to bridge diversity was lacking.

This wide community acceptance was identified with a willingness to support, in part, the aims and aspirations of several organizations (and their leaders), while at the same time finding a place for this part in a larger community pattern of service. In a typical case, the insistence of a women's group that it retain its identity as the originator and founder of a rehabilitation program was supported in part but only on condition that it join in a unified medical center. In other less successful cases, little room was left for this essential self-interest so that the final plans would have involved complete sacrifice by one agency in favor of another. Where the final sacrifice was demanded, the proposed plan was not acted upon.

Negotiating skill is the final characteristic associated with these individuals. In the successful cases negotiations had to be conducted over months or years. They involved matters of power and control, adjustment of age-old grievances and suspicions, and frank give and take to find a balance acceptable to contending groups. While the details may not be clear, it can be said that the critical role of leadership was exercised successfully when individuals were patient, aware of multiple alternatives, sensitive to groups' aspirations, and creative in devising new combinations to bridge the difference confronting the planning group.

These characteristics may be found among trustees or professional social workers. Unfortunately, the studies to date have not discriminated clearly between the roles of each. Participants in the planning in most instances attributed this leadership role to individual trustees and laymen, not to professional staffs of any organization. In fact, most respondents report that professional staffs of individual agencies played a negative or neutral role in the planning, while the staff of the planning federation was reported to play a facilitating role by keeping other leadership well informed and working out tactics. In no case was broad strategy attributed

to a professional staff. A few informants are convinced that the actions of professional staffs are more decisive than appeared in the data, but that their role is subtle and difficult to analyze precisely. They have urged that agency executives can initiate or destroy cooperation through their influence with their own trustees. Similarly, they believe that executives of planning groups frequently display the type of leadership attributed by other informants to trustees, and that professional staffs often prepare the objectives and strategy which guide planning.

It must be added that professional staffs were changed in each community where coordination was achieved. There is some indication that the new staff, selected for its interest in coordination, might have played a more positive role. However, much more study is necessary before clear-cut conclusions can be drawn about distinctions between professional and trustee leadership.

Discussion of leadership is often coupled with discussion of the function of personality in planning: the disruptions and obstacles caused by the personalities of the actors in every group situation; the difficulties created by arbitrary, self-centered, selfish, idiosyncratic individuals whose own needs are placed before group needs; the ideal characteristics sought after in welfare leaders, such as maturity, balance, community-mindedness, social responsibility, intelligence, and so on. In this investigation, the difficulties presented by the human vagaries of welfare leadership were found to be accepted as a normal condition in planning. Many informants commented upon special difficulties encountered, but explained this as an inevitable consequence of all interpersonal associations, increased by the struggle for power which underpinned much of the planning.

Unusual attention was directed to the role played by a few persons capable of dealing equally with these necessary characteristics of human intercourse. There was little suggestion that the standards for general welfare leadership could or should be modified to reduce the idiosyncracies of personality. Rather, stress was laid upon locating the balancing leadership that would be capable of working with the variety of individuals likely to be encountered. The negotiating and bridging skill referred to above is, in effect, success in working with many individuals with diverse personalities, goals and needs.

It is possible that the course of planning in any one of these communities would have been altered if different persons had been involved, but since welfare planning is seldom in a position to select or dictate the persons who rise to influence in welfare agencies, the survey informants chose to concentrate upon a manageable aspect of the subject.

Expert Studies and Consultations

In each community, the planning organizations and individual agencies undertook special studies of their needs and retained expert consultants to help them shape their plans of action. Their function in local planning has seldom been closely scrutinized. In the opinion of the key parties to planning in these cities these studies and the expert consultants brought from other cities played a useful but not vital part in the planning—a minor rather than major role. Although the survey teams identified certain contributions which were not given explicit recognition, the opinions of local leadership warranted first attention. In each instance it was established that the general lines for planning —more cooperation and coordination— had been settled upon by the key policy-making figures well before a study was attempted. This decision derived from local observation or exposure to currents of professional thinking at national con-

ferences and through the literature. A few respondents mentioned specifically the fact that they had attended such conferences and heard discussion of new ideas in health planning; some reported visits to institutions in other communities in connection with their business trips and observed experiments then under way (1946-1947).

In each community the surveys confirmed the beliefs of some of the local leadership as to deficiencies in local services, defects in quality in some institutions, and gaps in services. The surveys, therefore, served to reinforce local judgment when changes were proposed to various sectors of the community. In effect, some sanction, presumably more objective, was given to the local thinking. The consultants who were retained also were able to bring some experience from other communities about various means for coordinating or integrating programs, so that the practicability of local plans could be measured against experience elsewhere.

The studies and consultations appear to have been uniformly ineffective when it came to specific proposals for cooperation, coordination, or integration. Given a sentiment for some reorganization, how shall this be translated into operational reality? Should certain groups of patients be cared for in the hospital or in an infirmary of a home for the aged? How many or what kinds of beds should be built and where—at the home, the general hospital, or the sanatorium? How religious must some programs be if they are ever to be used by religiously orthodox members of the community? Is it clearly better to have one rather than two homes for the aged or two nursing homes? Should a rehabilitation program be developed within a hospital or in a separate, although adjoining, building? Experts provide answers to such questions on the basis of general knowledge and professional logic; they cannot make choices (where choices exist) on the basis of local history and power distribution. Thus, in one case a recommendation to merge two homes of quite different religious persuasion and relocate the combined unit near a hospital had a certain logic, but it was advanced with no knowledge of the local forces which made acceptance impossible.

In communities where expert recommendations were accepted literally, there was least progress. Success was found in those communities which used the expert advice as a point of departure for local negotiation and policy making. In these latter instances, the experts tended to be used as consultants to policy makers, answering questions and clarifying the issues or the consequences of certain acts compared with other alternatives. In the former cases, the tendency was to develop a report and blueprint and then leave it behind.*

The survey teams assessed the impact of expert studies upon planning and concluded that certain contributions were made which were undervalued by local informants. The most readily identifiable value lay in the wider horizons for planning which the expert reports opened up. In every instance, the special studies drew attention to the broad spectrum of community services required and thus rose beyond the special institutional interests of each organization. The most common example is the attention paid to care for the chronically ill and aged in their own homes, especially through recommendation for organized home care programs. The historical evolution of services in the six communities resulted in overemphasis upon inpatient and institutional care. As far as can be discerned, urgent proposals for noninstitutional programs

* In some instances the blueprint approach was dictated by the local agencies, although in others it was the preference of the consultant.

were first introduced by the expert consultants and studies. In four of the six communities, such programs were organized either as a part of the community plan or independently when the cooperative plan failed.

The expert studies also served, in retrospect, to focus and resolve local differences of opinion. They made proposals in sharp and clean-cut form. Once plans were projected by "an outside expert" they could be defended and attacked with a minimum "taking of sides" by local leadership. A certain amount of local antagonism was directed toward the "outsider"; feasible and unfeasible courses of action could be discerned, and more rational negotiation could proceed among local persons. Although the result could not always be identified as acceptance of the experts' report, a close examination of local events suggests strongly that the report played a vital role in the final outcome through deflecting antagonisms and permitting flexibility for local negotiation around clear alternatives.

These observations suggest reassessing the use of outside experts in local planning situations and point to greater emphasis upon the consultative role, reinforced by necessary fact finding, as against the more traditional "expert role" in which advice is given on a blueprint basis.

In reporting these differential local uses of expert opinion, it must be recognized that certain subtle influences were at work which may have been missed. A review of the expert reports makes clear that each of them stressed full coordination (built around the general hospital) and the undesirability of developing many programs in isolation from each other. It is impossible to judge with certainty whether some of these urgent recommendations may have been subtly absorbed by local leadership and been incorporated in their thinking "as their own." Such an explanation, appealing to those who rely upon expert judgment, is less than adequate for these cases. A comparison between the expert reports and the final plans reveals significant variations, although both types of proposals were in the general direction of more coordination.

To the extent that the expert studies threw their weight, no matter how great or small, on the side of cooperation or coordination, to that extent the central planning agencies can be said to have introduced this additional influence. In each case the experts were either directly retained by the federation or chosen by agencies through the channel of federation; they were distinguished professional men of unquestioned integrity, and their general support of coordination in medical planning was known. Their selection as the consultants of choice is significant in view of the availability of other equally eminent persons known to favor independent agency growth.

Incentives

Progress toward coordination in the six communities depended, in large part, upon the success with which planning efforts identified areas of common interest which appealed to individual agencies and satisfied their individual aspirations. Incentives were frequently used in the planning process—financial support, help in capital fund raising, appeals to civic pride, and promises of more prestigeful responsibilities. However, these incentives were, in no case, effective in overcoming or diverting agencies' views about their basic areas of self-interest. Where a common interest serving two agencies' needs could not be identified, coordination did not result.

Nevertheless, the studies indicate that the direction of change toward coordination can be influenced, if not com-

pletely determined, by a discriminating use of incentives on the part of planning groups. The evidence confirms that organizational change can be stimulated not only by discomfort, but also by the promise of greater satisfaction. In the successful plans, the long-stay institutions all assumed more significant positions in their communities after long years in which they offered substandard services in substandard facilities. As they acquired new buildings or additional funds for employment of more personnel for health service, they came to play a greater role in community medical care alongside a high-prestige hospital. In these instances, too, the general hospitals—which had been adequate but not especially distinguished in the medical community—became more prestigeful medical centers, with new physical facilities and with new geriatric, home care, and chronic illness programs reaching into the community.

In the less successful cases, certain rewards were finally bestowed upon wholly new institutions, and the resulting plans gave relatively little to the older organizations in the way of new plant or program or personnel.

Most of the successful incentives took the form first of financial increments for new buildings through federation-endorsed or -operated building fund campaigns. In some instances, leaders of some less prestigeful institutions were added to the boards of the hospitals. In others, funds were provided for new programs, such as a home care plan or a medical rehabilitation program or for more professional nursing staffs in nursing homes.

It must be pointed out that improvements had already been sought by each organization, but for its own objectives. In the joint planning, central federation support for these improvements was made explicitly or implicitly contingent upon continued participation in cooperative planning.

It may be asked, why was this effective when the financial aid from a central agency contributed such a small portion of the total operating costs of the individual agencies? The answer lies in an understanding of capital fund raising in private philanthropy. In both successful and unsuccessful cases, the program changes involved some additional capital financing. In the less successful cases, this fund raising was carried out with incomplete community support or support from some sectors of the giving public only. In the more successful cases, there was a wide area of support among many groups.

After some general consensus about coordination was reached in planning, it remained necessary to translate aims into details, and this in turn was dependent upon the amount of money which it was predicted could be raised. It is at this juncture that central planning is able to exercise crucial leverage on behalf of coordination. The execution of large plans was deemed dependent, in each case, upon widest possible financial support. Each agency, itself, could appeal to only a segment of the community. The federation represented the widest association of contributors. A nucleus of very large contributors was in each case likely to await federation approval of a program before committing its pledges to fund campaigns.

This approval does not necessarily involve monolithic control of the purse strings, or a monopoly of large contributors tightly banded together. Rather, it reflects a widely held opinion by fund raisers that large-scale fund raising does not flourish in the midst of a bitter controversy over its objects. Where a real controversy exists and can be quickly brought to the attention of large contributors, generous gifts are likely to be withheld by these persons, whether they act as individuals or as a group. On the other hand, where there is wide agreement about the objectives, the response

of large givers is believed to be more generous.

This interpretation is supported by the concentration of philanthropic giving in small segments of the populations of the communities studied—a fact which makes it comparatively easy to bring news of conflict or consent to major contributors. In two communities, contributors of $1,000 or more to an annual campaign constituted 2.1 per cent of all givers but accounted, respectively, for 58.8 per cent and 71.3 per cent of all contributions. This situation prevails in other communities examined.*

This view has not been objectively tested. However, it appeared to guide the key policy makers in each community studied. In three relatively successful cases, the funds for all plans were fully secured; federation support was thrown wholly behind proposals for coordination to which the key parties were willing to agree. In two less successful planning efforts, the resulting programs either failed financially or were constantly in danger of failing for lack of substantial support. These variations cannot be attributed to differences in financial capabilities, for the communities are relatively well matched in this regard. They can be explained by the policy followed by the federations in the matter of fund raising. In one case the federation supported a cooperative plan; in the other case it took a stand in favor of a plan accepted by some of the parties and opposed by others.

The use of financial incentives is not a black and white matter. Even in the unsuccessful cases, some organizations were able to secure partial support for their own programs, while in the successful cases the original scheme of cooperation or integration had to be modified and compromised to assure maximum financial support. On the other hand, the outright objection of the federation to a particular plan of coordination in at least one case did not materially affect the drive for funds, because the organizations were sufficiently powerful to offset federation disapproval.

One other commonly used incentive proved even less effective. In each community, the general hospital was highly valued for its services and could easily attract the support of the most respected members of the community. Other agencies, especially "custodial" institutions for the aged and chronically sick, were often assumed to rank lower in the estimation of the general community. Accordingly, it was concluded that such lower rated agencies would be eager to associate themselves with the high-ranking hospital.

The opposite was found to be true. The homes for the aged and the nursing homes were suspicious of any hospital tie. To them cooperation in any form spelled loss of identity, swallowing up by a very powerful competitor for funds and support, or institutional death—the attraction which high prestige was presumed to have proved to be nonexistent. The very status of the hospital in the community served to repel other institutions whose trustees expressed open fear and distrust.

This unexpected situation called for countervailing measures to obtain the consent of the homes to some form of coordination or cooperation: special protection of autonomy and identity, position on the policy controlling board of the hospital, or enhancement of responsibility for medical care for the chronically ill. Even with such added incentives, the resulting cooperation usually took the form of coordination of independent activities, not of integration.

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* Evidence from United Fund campaigns suggests that this concentration characterizes philanthropy in the general community, although the form is somewhat different. In 1956, gifts of over $100 provided 55.3 per cent of all funds raised by 93 community chests, but represented only 1.3 per cent of all subscribers.

The findings in the six communities permit the following conclusions:

1. Planning for cooperation can be furthered by financial and other inducements if a general meeting of minds has been reached.
2. Withholding of financial support does not preclude coordination or integration if agencies insist on it and are strong enough to go through with their plans.
3. Financial incentives alone cannot bring about coordination.
4. Incentives can speed movement of agency relationships in the direction of agency aspirations or, where a redirection is sought, can move them in the direction of coordination, provided the redirection is related to agency aspirations. Where this is not feasible, incentives are not an effective integrating tool.
5. Agency aspirations cannot be satisfied solely by association between two agencies with differing prestige rankings.

Summary of Major Conclusions

Planning to alter community health programs is a complex and subtle process. It touches the deepest roots of society, the way institutions organize their affairs, and the power relationships which bind many diverse groups together in a voluntary but cohesive community. There are few short cuts to action, and while broad principles are known, the technics for action have seldom been systematically evaluated. Planning is still more of an art than a science.

This review of experience in six communities sheds some light on several elements in the planning process. The elements are not new but the ways in which they operate in relation to each other have been only imperfectly perceived. The following conclusions are offered as a step toward defining the conditions and characteristics of effective planning. Much more study and research is clearly called for if the art of planinng is to be turned into a science of planning.

1. Every voluntary social agency is likely to express the predominant interests of one major group in a community, even though other groups are represented on the governing board of trustees. The predominating interests may reflect the cultural, ethnic, economic, social, or religious goals of one segment of a community and are expressed through representative leaders.
2. Planning for social welfare requires that attention be given to the interests of controlling groups as well as to the logic of any welfare problems.
3. The success or failure of community planning to coordinate welfare services is likely to be determined by the extent of informal social interaction which has developed among trustees of agencies involved in each planning effort.
4. Welfare planning is facilitated if action is initiated when each of the involved agencies is undergoing a major internal change or crisis in its operations. These changes may be due to changes in financial support, personnel, leadership, technology, demands for service, or other events which are not subject to internal control.
5. Community planning in a voluntary association requires a structure, mechanism, or organization in which involved agencies have substantial confidence. If such a mechanism does not exist, the imperatives of voluntary planning require that one be consciously created. (a) A history of objective action by the planning organization is as important as technical competence for making current decisions. (b) The planning organization is most successful when it has created an image of itself as impartially interested in the aspirations of all of its affiliates; concerned with widest community interest, rather than the needs of one agency; and identified with all economic and social sectors rather than with any one. (c) Planning groups are especially effective when they develop a position on broad goals and principles, but permit details to emerge through voluntary negotiation and agreement.
6. Individual leadership, difficult to define precisely, is a second essential element in planning. Successful leadership for coordination requires: (a) a capacity to bridge the trustee interests of conflicting groups; (b) a readiness to consider at least in part the aims of several organizations; (c) patient negotiating skill and imagination to blend special interests into a pattern of community-wide service. The study did not succeed in distinguishing the special functions of professional as compared with trustee leadership. However, some informants believe that the attitude, strength, and imagination of the profes-

sional leadership in social agencies color and often determine the direction of community planning.

7. Special studies and consultations by nonlocal experts are useful tools in local planning, but they are not as decisive as has been commonly assumed. Expert studies support local forces already seeking to change the past pattern of coordination; they seldom produce acceptable specific proposals for new organization. (a) The use of outside expert studies in planning needs to be reviewed with emphasis upon the expert as a consultant to local policy making, rather than solely as a reporter of facts or recommender of policy. (b) Experts from other localities, and expert studies generally, can and do direct attention to the benefits of comprehensive planning. They frequently help local groups to comprehend the totality of a social or health problem and thus to rise above the more narrow preoccupations of specialized agencies.
8. Incentives in form of financing or prestige are useful in any community planning, but they are not decisive. They are tools to be used with discrimination by sensitive leadership to further objectives agreed upon in voluntary planning.

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Sixth Graders Sponsor Adult Health Screenings

A New Haven, Conn., school was the scene in April, 1962, for an unusual one-day neighborhood health screening program—when 14 different chronic disease tests were offered to a total of 441 persons at no charge through the combined efforts of voluntary and public health agencies, community physicians, public health nurses, and other volunteer personnel. Sponsored as a Community School Program by sixth grade pupils who developed classroom demonstrations on the health screening efforts and who obtained support of adults in the local Community Council, the tests were carried out in seven stations set up in the school, two other stations serving as a center for health education information and the continuous showing of health films. Abnormal findings in weight, vision, hearing, blood pressure, electrocardiograms, cholesterol levels or chest x-rays, as well as in tests for cancer, glaucoma, diabetes, syphilis, and gonorrhea were referred to the physicians designated by the participants. Where no doctor was designated, public health nurses visited the participants at home to encourage them to seek medical supervision. The total cost of the program, heavily supported by volunteer efforts, was estimated as under $100 spent for supplies, representing a cost of less than five cents each for the more than 2,000 tests administered. Further information may be obtained from Seymour Rotter, Health Secretary, Community Council of Greater New Haven, Inc., 397 Temple St., New Haven 10, Conn.